



REQUIREMENTS FOR MEMBERSHIP

Membership with VKL is straightforward. **When you have all the documents listed below.** Telephone Marilyn Everitt-Drew our Registered Manager on 0208 381 6254 to **MAKE AN APPOINTMENT FOR REGISTRATION** this will ensure your application is dealt with quickly and as smoothly as possible. No one can start work without providing the required documents. I.D. badges will only be processed when two references have been submitted to VKL.

- Fully completed application form with **no gaps** in employment or education history we require this in addition to your CV. Also to include details of two professional references **one must be from recent manager** (With full names business addresses, telephone numbers)
- **Passport** / Birth certificate
- **Proof of address** / Photo ID / Driving licence/ Utility Bill
- **National Insurance Card and P45**
- **Bank/Building Society Details**
- **Payment for CRB £45.00** Enhanced Disclosure From 12th October 2009 it will be a criminal offence to employ anyone (Paid or Unpaid) in regulated activity without checking they are not on a national barred list - this means doing an enhanced CRB
- **Payment for Induction £120.00** If you are new to care you will have to complete the VKL Induction course at a cost of £120.00 Please enclose full amount with the completed application form for short courses. **Mandatory**
- **Payment for Badge £5.00** / badges will be issued when all documents have been submitted
- **Proof of Vaccinations (Hepatitis B, TB, Rubella, Tetanus, Varicella)** form enclosed **Mandatory**
- **All Training Certificates** including NVQ and any other Training certificates (Healthcare Assistants)
- **Proof of Secondary Education** Certificates or ILETS Cambridge Certificate for English (5.0 speaking and listening)
- **Employment Record (recent C.V.)**
- **NMC Pin Number** with letter of Statement of Entry (for Registered Nurses)
- If you are a student, please bring admission letter acceptance as proof

Please bring Correct Payment and Original documents when attending for an interview.



Application Form for Membership

POSITION APPLIED FOR:

RMN* RGN* Care Assistant
**must have an English NMC number in order to apply as a nurse*

Date of application:

UK STATUS

British Indefinite leave to remain/permanent Residence Dependant Student Nurse Student other
 Work Permit Holder Asylum Seeker

Valid from:

Valid Until:

Ref Number:

PERSONAL DETAILS

Title: Mr. Mrs. Miss. Ms.

First Name:

Surname:

Date of birth:

Marital Status: Married Unmarried Divorced Separated

Current address:

City:

County:

Postal Code:

Email:

Telephone 1:

Telephone 2 (mobile):

NATIONAL INSURANCE

National Insurance Number:

NURSING QUALIFICATION *(applies to nurses only)*

Nursing Qualification: Diploma Degree Masters Higher

Date of Qualification(s):

Nursing and Midwifery Council (NMC) PIN number:

Date of Registration:

PASSPORT DETAILS

Nationality:

Passport Number:

Date of Issue:

Expiry Date:

NEXT OF KIN (IN CASE OF EMERGENCY)

Full Name:

Title: Mr. Mrs. Miss. Ms.

Capacity in which the person is know to you:

Address:

City:

Country:

ZIP Code/Postal Code:

Email:

Telephone 1:

Telephone 2 (Mobile):

Employment Details

Please give full details of work history for the previous six years, identifying and giving details of any significant breaks.
Current / most recent position

NAME AND ADDRESS OF EMPLOYER	POSITION HELD	FROM	TO	SUMMARY OF RESPONSIBILITIES TYPE AND SIZE OF UNIT

Education

NAME OF SCHOOL COLLEGE UNIVERSITY ATTENDED	FULL OR PART TIME	FROM	TO	COURSES TAKEN OR CURRENTLY STUDYING	EXAMINATION RESULTS INCLUDING GRADES

Experience

QUALIFIED NURSES ONLY									
<i>(Please tick the areas that describe your work experience)</i>									
Experience	Less than 6 months	More than 6 months	1 -2 years	2+ years	Experience	Less than 6 months	More than 6 months	1 – 2 years	2+ years
A & E					Mental Health				
Anaesthetic Trained					Midwifery				
Ante Natal					Neonatal				
Cardiac					Neurology				
Cardiothoracic					Nursing Homes				
Care of the Elderly					Occupational Health				
Chemotherapy					Ophthalmology				
Community Nursing					Orthopaedics				
Day Care Centre					Out Patients				
Day Surgery					Paediatric				
District Nursing					PICU				
Family Planning					Practice Nurse				
Gynaecology					Prisons				
Haematology					Recovery				
Health Visitors					Renal				
High Dependency Unit					Residential Homes				
Home Care					SCBU				
Hospices					School Nurse				
Hospitals					Scrub				
In Charge Duties					Stoma Care				
Intensive Care Unit					Surgical				
ITU Psychiatric					Termination Clinic				
Learning Disability					Theatre				
Medical					Urology				
Medical Assessment Unit / PAU									

HEALTH CARE ASSISTANTS ONLY									
<i>(Please tick the areas that describe your work experience)</i>									
Experience	Less than 6 months	More than 6 months	1 -2 years	2+ years	Experience	Less than 6 months	More than 6 months	1 – 2 years	2+ years
Nursing Homes					Home Care				
Residential Homes					Senior Care				
Private Homes					Catheter Care				
Hospitals					Fluid Charts				
Schools					Urinalysis				
Community Care					NVQ				
Learning Disability					Observations BP/TPR				
Mental Health					Observations				
Paediatrics					NNEB				

Professional References

REFERENCE 1 (PRESENT/MOST RECENT)	REFERENCE 2
Name:	Name:
Position:	Position:
Employment Address:	Employment Address:
Email:	Email:
Telephone:	Telephone:
May we approach this referee: Yes/No	May we approach this referee: Yes/No

Medical History

Medical History	Yes	No	Details
Have you ever been treated at hospital for serious illness or surgery? Please give details			
How much time have you lost from work due to illness in the last five year? Please give details			
Are you a registered disabled person?			
What is the date of your last chest x-ray?			
Have you ever suffered from any of the following?			
Heart / Circulatory illness / Hypertension			
Diabetes			
Asthma / Hayfever			
Bronchitis / Pneumonia / Pleurisy			
Tuberculosis			
Epilepsy / Frequent Fainting Attacks			
Headaches / Migraine			
Psychiatric Illness / Anxiety / Depression			
Dermatitis / Skin Sensitivity (Allergies) Psoriasis / Eczema			
Back Injury / Back Problems or Back Pains			
Recurrent Infections e.g. Sore Throats / Ear Infections			
Hepatitis / Jaundice			
Are you receiving medicines, pills or tablets from a doctor or on a prescription?			
Do you have any physical disabilities other than those listed above that could affect your ability to carry out your assignment?			
Have you been immunised against the following? Please provide evidence of vaccinations or immunity.			
Tuberculosis			
Rubella (German Measles)			
Poliomyelitis			
Hepatitis B			
Tetanus			
Typhoid			
Chicken Pox			
Any Other			
Do you smoke?			

I declare the statements are true and complete to the best of my knowledge and belief

Signed:

Dated:

Rehabilitation of Offenders Act 1974 England

The provisions relating to the non-disclosure of criminal convictions do not apply to certain occupations and activities. The position for which you are applying is one which is exempted under the above order. Therefore it is necessary for you to disclose any criminal convictions, even if, under the Rehabilitation of Offenders Act, they would otherwise be regarded as "spent"

Have you ever been convicted of any criminal offence? YES / NO

Do you have any criminal charges pending? YES / NO

If you have answered yes to either of the above, please give details:

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NB. Any information disclosed will be taken into consideration but will not automatically prevent your application from proceeding. However, if you are appointed, failure to disclose any criminal conviction could lead to termination of our ability to act as your agent.

Rehabilitation of Offenders Act 1974 England

1. I confirm that the information set out in this form is true and correct, is not misleading and that no material information had been omitted. I understand and agree that if I submit any false or misleading information, this may result in any offer of registration with the agency being withdrawn, or, if already accepted in my dismissal.
2. I hereby authorise VKL Nursing Health and Social Care Training Centre Ltd. to secure all information it may require in connection with my application for registration, Subject to any specific direction I have made related to contacting my referees.
3. I confirm that I have read and understand the conditions of engagement offered by VKL Nursing Health and Social Care Training Centre Ltd. and agree to be bound by and comply with the same.
4. I have no objection to my details being held on computer records and utilised by the company in pursuit of its legitimate business.
5. I understand that my application is subject to the receipt of satisfactory references, Police clearance and any other checks (where appropriate).
6. I agree to inform VKL Nursing Health and Social Care Training Centre Ltd. of any changes or additions to the information I have supplied.

Declaration

I declare the information given in this application form is true and complete to the best of my knowledge and belief. I authorise VKL Health and Social Care Training Centre to make any other enquiries to support my application. I agree to respect the confidentiality of patients and clients and any other information I may have access to at all times.

Signed..... Date.....



IF YOU DO NOT ALREADY HAVE WRITTEN PROOF OF ALL OF THE IMMUNISATIONS LISTED BELOW you are required to **consult your GP or practice nurse** to complete this form prior to starting work placements with this Agency. **It is your responsibility to pay for any charges your GP may make for immunisations.** It is very important that you commence your immunisations as soon as possible as it may take several months to fully complete the course.

NB. YOU MUST HAVE TB AND RUBELLA SCREENING AND HAVE COMMENCED THE HEPATITIS B COURSE BEFORE YOU WILL BE ALLOWED TO WORK. IN ADDITION YOU MUST NOT HANDLE BLOOD AND BODY FLUIDS UNTIL YOU HAVE COMPLETED THE HEPATITIS B COURSE AND HAD A BLOOD TEST TO CHECK FOR HEPATITIS ANTIBODIES.

NAME OF APPLICANT _____

DATE OF BIRTH _____

VACCINATIONS	DATE	BOOSTER DATE	GP'S OR PRACTICE NURSE NAME (BLOCK CAPITALS) AND SIGNATURE
HEPATITIS B	1		
	2		
	3		
Varicella			
Rubella			
Tuberculosis			
Tetanus			

SCREENING (blood tests)	DATE	RESULT	GP'S OR PRACTICE NURSE NAME (BLOCK CAPITALS) AND SIGNATURE
Post vaccination Hepatitis B antibodies			
Varicella Zoster Virus Antibodies (if not had chicken pox)			
Rubella Antibodies			
TB screening (heaf/mantoux/tine) Only if no BCG scar. Confirm scar seen.			

PLEASE SEND COMPLETED FORM WITH YOUR APPLICATION FOR EMPLOYMENT

OFFICIAL SURGERY STAMP



Equal Opportunity Monitoring Form

VKL Health & Social Care Training Ltd aims to be an equal opportunity company and selects staff solely on merit irrespective of race, sex, disability etc. In order to monitor the effectiveness of our equal opportunity policy we request all applicants to provide the information indicated below. Completing this form will help to assist the monitoring of our workforce to be representative of the local community and to target any under represented groups.

Please Note: Ethnic minority questions are not about nationality, place of birth or citizenship. They are about colour and broad ethnic groups – UK citizens can belong to any of the groups indicated.

My sex is Male Female

Ethnic Origin

I would describe my ethnic origin as:		Please tick one box
White	British	
	Irish	
	Any other white background *	
Mixed	White and Black Caribbean	
	White and Black African	
	White and Asian	
	Any other mixed background *	
Asian or Asian British	Indian	
	Pakistani	
	Bangladeshi	
	Any other Asian background *	
Black or Black British	Caribbean	
	African	
	Any other Black background *	
Chinese	Chinese	
*Other ethnic group	Please state:	

Is there anyone who relies on you for day-to-day care and attention? YES/NO

If YES, are they: a) Children
 b) Other family member or partner

Do you consider yourself to have a disability? YES / NO

My age is: (please tick appropriate box)

16 – 19 40 – 49
 20 – 29 50 – 59
 30 – 39 60 – 64

Thank you for completing this form